MMSO DENTAL TREATMENT REFERRAL FORM

Oral Health Initiative?
If this patient was referred under the initiative to increase dental Class I status, please check YES. Otherwise, check NO.

YES_____ NO _____

Date Referred: _____
Treating Office:
_____

Date Completed: _____

Referring Military Dental Treatment Facility (DTF):

Phone:
Fax:

Treatment Authorized:

Dental treatment as specified below, and any necessary radiographs (bitewing or periapical) as needed to perform treatment.

#1 _____	**#17** _____
#2 _____	**#18** _____
#3 _____	**#19** _____
#4 _____	**#20** _____
#5 _____	**#21** _____
#6 _____	**#22** _____
#7 _____	**#23** _____
#8 _____	**#24** _____
#9 _____	**#25** _____
#10 _____	**#26** _____
#11 _____	**#27** _____
#12 _____	**#28** _____
#13 _____	**#29** _____
#14 _____	**#30** _____
#15 _____	**#31** _____
#16 _____	**#32** _____

Other Procedure(s): (biopsy, SC/RP, or other procedure not identified by tooth number)

_____

_____

DTF Address:

_____

For significant adjustments to treatment plan, please contact the referring military DTF listed above.

Within 7 days of completion of care, please mail, fax, or have the patient hand carry an info copy of the bill/claim for the completed treatment to the DTF listed above.
To file the claim for payment, follow the instructions below.

Claims Processing:

Upon completion of treatment, mail:

1. **A copy of this Referral Form**
2. **Standard ADA Dental Claim Form**
3. **MMSO Dental Information Sheet**

To:
Military Medical Support Office
Attention: Dental Claims
P.O. Box 886999
Great Lakes, IL 60088-6999

MMSO Customer Service
1-888-647-6676

Comments: _____

_____

_____

_____

_____

Provider's Printed Name/Stamp	**Provider's Signature**	**Urgency of Care** **( ) Emergency** **( ) Routine** **( ) Next Available**
Patient's Name: Last, First, MI	**Rank**	**SSN**
Patient's Address	**Work Phone**	**Home Phone**

This form is affected by the Privacy Act of 1974, and this information is protected by all HIPAA policies and guidelines **08 Nov 05**